Multiple Family Groups: An engaging mental health intervention for child welfare involved families

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Purpose

We examine preliminary data of the Multiple Family Group (MFG) effectiveness study to determine how child welfare and non-child welfare involved families differ regarding perceived barriers to treatment and treatment attendance.
Mental Health Status of Children with Child Welfare Contact

- High rates of emotional and behavioral difficulties \(^{(1,2)}\)
  - Child Maltreatment \(^{(3)}\)
  - Other family stressors \(^{(4-9)}\)
- Few engage or remain in mental health treatment, particularly if they remain with their caregivers \(^{(10)}\)
- Low service capacity and high rates of youth behavioral problems in urban settings \(^{(11,12)}\)
Barriers to Treatment for Child Welfare Involved Families

- Transportation (13)
- Money (13)
- Conflicts between work and mandated services (13)
- Child care (13)
- Extreme family stressors (14)
- Mandated status (15,16)
- Prior negative experiences with service providers (17,18)
- Stigma (19,20)

- Child welfare families are more likely to report greater barriers to treatment.
- Greater barriers to treatment are linked with greater risk of premature termination (21,22).
- Child welfare involved families are more likely to terminate prematurely and manifest reduced attendance rates (23,24).
Multiple Family Group Service Delivery Model

- Multiple Family Group (MFG) is a service delivery strategy meant to enhance child mental health service use and mental health outcomes for urban, low-income children of color (25-30)
- MFG content and process was designed in collaboration with parents & providers
- Series of weekly group meetings with 6-8 families
  - Melding group therapy, family support, systemic family therapy, and behavioral parent training
  - 12- and 16-session version
MFG Service Delivery Model

- Strengthens parenting skills and family relationship processes
  - child management skills
  - family communication
  - within family support
  - parent/child interaction
- Addresses factors affecting service use and outcomes
  - parental stress
  - use of emotional and parenting support
  - stigma associated with mental health care
Multiple family groups should focus on: (4Rs)

- **Rules**
- **Roles and Responsibilities**
- **Respectful communication**
- **Relationships**

- As well as the 2Ss:
  - **Stress** and **Support**
MFG Service Delivery

- Clinician and parent advocate co-facilitate
  - Clinicians provide professional expertise
  - Parent advocates provide support and practical information
- Targets logistical and perceptual barriers
  - child care
  - transportation expenses
  - dinner
  - non-stigmatizing group setting
  - Frequent phone contact between sessions
- Sessions guided by a manual characterized by flexibility, choice of activities, discussion questions
Research Questions for Current Study

Among those participants involved in MFGs, how do child welfare and non-child welfare involved families differ regarding

1. perceived barriers to treatment at post-test?
2. MFG treatment attendance?
Sample

- Randomized effectiveness trial of MFG vs. services as usual in 13 outpatient clinics across NYC
  - Youth 7-11 and their families
  - ODD or CD
- n = 224 children enrolled in the MFG experimental group
- No children in foster care
Sample

- “Child Welfare Involved”: n = 83
  - at baseline, having a current or history of an open child welfare case
  - having ever had a child placed in foster care
  - been referred and/or mandated by a child welfare organization to bring their child to counseling or other services
  - sought services in order to receive full custody of their children or to avert child removal from the home

- “Non Child Welfare Involved”: n = 141
Baseline demographic characteristics

- No statistically significant differences ($p < .05$) were found between child welfare and non-child welfare involved participants.
- Largely low-income (65% reported income less than $20,000 per year).
- Black or Hispanic (79%).
- Single-parent (65%).
- Few caregivers attained a post-high school education (34%).
- Close to one-third of caregivers (32%) reported being unemployed.
Measures

- Kazdin Barriers to Treatment Scale – post-test only
- MFG Attendance
  - Average Total # sessions attended
  - % attendance per intervention quarter

<table>
<thead>
<tr>
<th>% Attendance</th>
<th>16 Sessions (n = 179)</th>
<th>12 Sessions (n = 45)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st quarter</td>
<td>Sessions 1-4</td>
<td>Session 1-3</td>
</tr>
<tr>
<td>2nd quarter</td>
<td>Sessions 4-8</td>
<td>Sessions 4-6</td>
</tr>
<tr>
<td>3rd quarter</td>
<td>Sessions 9-12</td>
<td>Sessions 7-9</td>
</tr>
<tr>
<td>4th quarter</td>
<td>Sessions 13-16</td>
<td>Sessions 10-12</td>
</tr>
</tbody>
</table>
Analyses

- Wilcoxon Mann-Whitney tests to compare barriers to treatment and total MFG sessions attended for child welfare vs. non-child welfare involved families.

- Random effects regression modeling was used to examine differences in attendance between child welfare and non-child welfare involved families over time.
  - Time is modeled as 4 intervention quarters.
## Results

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (n = 224)</th>
<th>Child Welfare Involved (n = 83)</th>
<th>Non-Child Welfare Involved (n = 141)</th>
<th>Sig&lt;sup&gt;a&lt;/sup&gt;.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean (SD)</td>
<td>Md</td>
<td>n</td>
</tr>
<tr>
<td>KBT Scale</td>
<td>155</td>
<td>60.12 (17.66)</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Attendance</td>
<td>223</td>
<td>8.93 (4.91)</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>12 Sessions</td>
<td>45</td>
<td>8.18 (4.02)</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>16 Sessions</td>
<td>178</td>
<td>9.12 (5.10)</td>
<td>10</td>
<td>67</td>
</tr>
</tbody>
</table>

Note: Numbers may not add up to n=224 due to missing data

** p < .01; NS: not significant (p < .05)

a. Mann-Whitney tests comparing differences between child welfare and non-child welfare groups
Results

Percentage MFG Attendance Over Time

- non childwelfare (n = 140)
- childwelfare (n = 83)
- total (n = 223)
Multivariate analyses comparing MFG Attendance over time by Child Welfare Status

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>SE</th>
<th>Z</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>intercept</td>
<td>0.70</td>
<td>0.03</td>
<td>23.16</td>
<td>0.00 **</td>
</tr>
<tr>
<td>Child Welfare(^a)</td>
<td>-0.02</td>
<td>0.05</td>
<td>-0.49</td>
<td>0.62</td>
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<tr>
<td>Quarter</td>
<td>-0.04</td>
<td>0.01</td>
<td>-3.68</td>
<td>0.00 **</td>
</tr>
<tr>
<td>Child Welfare X Quarter</td>
<td>-0.01</td>
<td>0.02</td>
<td>-0.52</td>
<td>0.61</td>
</tr>
</tbody>
</table>

** p < .01

\(^a\) Child welfare status indicator: 0 = non-child welfare involved, 1 = child welfare involved
Preliminary results on outcomes

- Child Welfare involved families participating in the MFG experimental condition manifested statistically significant changes from baseline to post-test (n = 61):
  - Reduced child inattention symptoms ($t = 3.41, p < .01$)
  - Reduced levels of parent stress ($t = 2.57, p = .01$)
  - Enhanced family organization ($t = 2.13, p = .04$)
  - Enhanced family communication ($t = -2.08, p = .04$)
  - Greater levels of child social skills ($t = -2.58, p = .01$)
Implications

- Despite greater perceived barriers to treatment, treatment attendance rates may be attributed MFG engagement practices:
  - Frequent phone contact
  - Childcare, transportation, dinner
  - Non-stigmatizing group format
  - Parent advocates as facilitators

- Attendance rates typically exceed those seen in urban child mental health clinics (31,32)

- Fits with “family to family” philosophy in child welfare
Limitations

- Small sample of child welfare involved participants (n = 83)
- Parent reports of child welfare involvement
- No comparison group of equal length to fully compare attendance rates
- Sole reliance on attendance rates to measure engagement
Future Research

- Qualitative study exploring reasons for engagement among child welfare involved MFG caregivers
- Quantitative study examining child welfare status as a moderator of MFG treatment outcomes
- Other recommendations:
  - Using administrative data to identify child welfare status and differentiate by maltreatment subtype and level of involvement
Thank you!

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References


References

31. McKay et al., 2002